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ABSTRACT

Tips are offered for psychologists who teach behavioral science to first-year medical students, based on a course offered at Creighton Medical School. It is suggested that medical students will work hard and are interested in learning topics that will be useful. It is important for the psychology instructor to teach a body of knowledge to medical students to show a respect for the importance of the subject. Some teachers of psychology present topics that are too broad and tell students not to take notes. However, it is best to construct the behavioral science course differently from harder sciences such as anatomy and biochemistry. While it is necessary to make sufficient demands so that students will study and learn the material, capricious and overly painful requirements are not appropriate for the course, which is their first clinical course. In addition, this first-year course should not be overidentified as a psychiatry course. The most successful lecturers provide outlines, since medical students are under pressure to assimilate massive quantities of information. Practical demonstrations of psychological techniques, such as deep muscle relaxation, are valuable. A mini-segment can address medical school stress and how to deal with it. (SW)

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DEVELOPING THE PSYCHOLOGIST'S CREDIBILITY IN TEACHING FIRST-YEAR MEDICAL STUDENTS

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Developing the Psychologist's Credibility in Teaching
First-Year Medical Students

I have been teaching medical students for twelve years. I've directed the Division of Behavioral Science for ten.

Psychologists generally -- as reported in the literature -- and specifically in my own experience -- feel as they begin teaching in medical school that they must have committed some horrible crime for which they now are being punished.

It is scant consolation to discover that psychiatrists suffer some of the poor reception and credibility problems as do psychologists.

Ten years ago I attended the Annual Meeting of the Association of Directors of Medical Student Education in Psychiatry for the first time. Everyone there said that the first-year course was torture at best. Last June the speaker who addressed the first-year course said essentially that things were just as bad as ever. "Students are too anxious and have too much to learn." He pleaded not to "abandon the first year," suggesting we provide electives on identity of a physician, that we be active at orientation, that we establish a psychiatry club, and that we offer therapy to individual students which sounds to me like what he's really saying is "Let's abandon the first year."

In summary, M-1's, as they're called, give short shrift to Behavioral Science and make the course painful to instructors in the process.

The situation at Creighton Medical School is much better for me and for my course. When I began, students rated me #10 of 10 lecturers. Now I'm #1 or #2 at almost every evaluation..

We have better attendance at Behavioral Science than do most of the other courses in the school. We finally knew for certain we were doing something right when the students asked the Biochemistry Department to reschedule an examination so it did not interfere with the B.S. exam.

B.S., incidentally, stands for Behavioral Science. We tried calling it Behavioral and Social Medicine one year, but the students began referring to it as Bazoom, so we've settled for B.S.

I tend to be a fairly obsessive fellow, and so I view the world in terms of rules. And like the rat who has finally found a way around the electrified grid, I tend to be rather dogmatic and rigid about my rules. So take them for what they're worth, but I can summarize my learning experience in six minutes and five rules.

Rule #1. Know the student.

Corollary A (I said I was an obsessive fellow) Medical students are not graduate students. They are not interested, for instance, in whether an argument can be made that functionally there is no difference between classical and operant conditioning. They are interested in things that will be of use to them. Psychologists tend to run into trouble with this rule.

Corollary B - Medical students are students. They are interested in learning and are willing to work to do so. Psychiatrists, in my experience, have trouble with this rule. -- They all too frequently present topics a bit too broadly with frequent comments such as "Don't bother to take this down."

Or "You don't need to remember this" or "you'll get this better in your Pharmacology course. It is important to teach a body of knowledge to them to show you respect the importance of what you're trying to convey.

Rule #2. Don't try to compete directly with the harder sciences such as anatomy or biochemistry.

Such departments all too frequently seem to operate within the John Mitchell school of motivation. -- I'll be happy to refresh anyone's memory about privately after the program -- these departments will win every time primarily because psychologists rarely have either the power or the stomach for sustaining such direct competition.

We have found it much more successful to compete indirectly by construing our course as different from the other first-year courses. We are their first clinical course. Behavioral Science is an applied course which will give them information they will use with patients a year and a half from now. It is important to make sufficient demands on the students such that they will study, such that they will learn the material, such that they will have respect for the course -- but not demands that are unnecessary and capricious or overly painful.

I think our department has been successful in maintaining this delicate balance by making a conscious -- no, a very self-conscious -- decision to try to role model in our teaching what we hope they'll learn to be as practitioners -- that is, both highly competent in their skills and humanely patient-centered in their delivery of those skills. So, for example, we give

them a very clear message that there are rather unfortunate consequences to failing the course, but that we will go out our way to insure their passage by tutoring, by providing makeup examinations, etc.

Rule #3 -- Don't overidentify the first-year course as a psychiatry course.

Such overidentification misleads students into thinking the material applies just to the practice of psychiatry and that real physicians don't need to worry about it. The vast majority of students are not interested in becoming psychiatrists. We've tried to deal with this problem in a couple of ways.

On the one hand, we've arranged for about every fourth or fifth lecture to be presented by a nonpsychiatric physician on an appropriate topic. For instance, we have a pediatrician discuss how a child's developmental stage affects medical treatment of that child.

Having physicians give many lectures also falls under Rule #2 -- not competing directly with anatomy. It's a way of saying that anatomy is necessary background for you, but Behavioral Science is the real thing. This is the practice of medicine.

On the other hand, we've created some role diffusion if not confusion. Normal human sexuality is covered mainly by psychiatrists. The paraphilias are taught by a sexual therapist whose doctorate is in sociology, and I teach psychopathology.

Rule #4 -- Medical School is stressful. Conform. At our medical school, all students carry from 25 to 30 credit hours

of work each semester, and there are no punt courses. Failing grades in any course must be remedied before the student is allowed into the next year. Students are under tremendous pressure to assimilate massive quantities of information. They are programmed for lectures which outline this information. If a lecturer does not conform to this model, it makes the student nervous. We have found our most successful lecturers are those who provide outlines for the students to follow and which periodically during the presentation specify what the student is expected to later regurgitate. I am referring here to the format, not the content. Even highly theoretical material can be conveyed comfortably to these pressured students if occasionally one provides a list of things to be memorized.

Rule #5. Some students need proof, but a little proof goes a long way.

In every first-year class, there is a group of hardcore biophysicists who are very reluctant to accept psychological knowledge as real.

To address the needs of these folks, we go out of our way to periodically present some highly psychological data in the context of the hardcore research methodology that derived them. This helps a little.

Much more effective, however, have been a few practical demonstrations. Several years ago one of the faculty cancelled his lecture five minutes before class on a topic I was unfamiliar with. I didn't want to lose the hour, so I offered to demonstrate deep muscle relaxation. We had discussed systematic desensitization

of phobias, so it seemed relevant. I turned down the lights and ran through the procedures with the entire class. Later on several students approached me to say, "Hey, this psychology junk really works." Another wanted treatment for a phobia. Since then we've planned a mini segment of the course to address medical school stress and how to deal with it. We include this demonstration and other specific techniques, for instance, Robinson's SQ3R method of study, techniques for falling asleep, etc. The students seem to generalize from these experiences to other topics we teach in the course.

Now what does this have to do with developing a credibility of the psychologist. My bias is that the psychologist will be credible with first-year medical students only insofar as he/she is associated with an effective teaching program that meets the students' needs.